Vinada Limited - Voguehaven Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Vinada Limited
Premises audited:	Voguehaven Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 July 2017 End date: 13 July 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 24

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Voguehaven Rest Home provides rest home level care for up to 26 residents Occupancy during the audit was 24 residents. Two directors (manager/ and daughter) have the responsibility of the daily operations and oversee the delivery of services. All family and residents interviewed spoke positively about the care and support provided by staff and management.

This surveillance audit was conducted against aspects of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner

Five of seven shortfalls identified at the previous audit have been addressed. These were around the complaints action report, quality programme implementation, registered nurse assessment of incident forms, activity plan reviews and food temperature recordings. Further improvements continue to be required around interRAI assessments and care plan interventions.

This audit has also identified improvements required in relation to: two yearly mandatory training, staff files documentation, documentation of progress notes and restraint register.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Residents and staff report full information is provided at entry to residents and family/representatives. Regular contact is maintained with family. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Voguehaven has made improvements around implementation of their quality and risk management system since the previous audit. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Action plans are implemented when areas for improvement are required. Health and safety policies, systems and processes are implemented to manage risk. All staff have an orientation on employment and there is a documented training plan. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurse (RN) is responsible for each stage of service provision. The RN assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Resident files included medical notes by the contracted GP and visiting allied health professionals. The activities team provides an activities programme for the residents. The programme runs during the day over five days a week.

Medication policies comply with legislative requirements and guidelines. Staff responsible for administration of medicines completes education and medication competencies. All meals and baking are done on site. Residents' food preferences, dietary and cultural requirements are identified at admission and in an ongoing manner and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The building holds a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

There are policies around restraint, enablers and the management of challenging behaviours. The service currently has no residents assessed as requiring restraint and one resident using an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	3	0	0
Criteria	0	35	0	2	5	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. The manager/director maintains a record of all complaints, both verbal and written by using a complaints book (register). There have been no complaints made in 2016 and 2017 year to date. There is a documented complaints action report in place. The previous certification audit finding has been addressed. Residents and family members interviewed advised that they are aware of the complaints procedure.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Management promote an open door policy. Five residents interviewed stated that the staff and management are approachable and available. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed identify that family were notified following a resident incident. Three relatives interviewed confirmed they are notified of any changes in their family member's health status. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Interpreter services are available as required.

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Voguehaven is a 26-bed rest home, which provides a homely environment. On the day of audit there were 24 rest home residents. The manager/director has the responsibility of the daily operations and oversee the delivery of services. The manager/director has an aged care national certificate and has considerable experience (15 years) in caring for the elderly. A part-time registered nurse (RN) supports the manager/director (12 hours a week). The two directors (manager and daughter) formally meet two times a year. The agenda includes health and safety, infection control, restraint, audit outcomes and quality initiatives. There is a current governance quality plan for 2017-2018. Goals identified included (but are not limited to) upgrade the accommodation and environment, retain effective staff members and maintain occupancy above 94%. There have been environmental improvements and replacement of equipment. The refurbishing plan is ongoing. Staff interviewed confirmed the communication levels are good and the staff work together as a team. Residents and families speak highly of the staff and the services provided. The Voguehaven manager/director has attended at least eight hours of training relating to the management role. The RN maintains relevant professional development hours. A current annual practicing certificate was sighted.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There are policies and procedures to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management committee responsibilities and internal audit schedule. Staff have input into the staff meetings. Minutes sighted evidence there is discussion around complaints, compliments, health and safety, infection control and quality initiatives and improvements. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Health and safety policies, systems and processes are implemented to manage risk. Staff interviewed state they are well informed and receive quality and risk management information such as accident incident graphs and infection control statistics. Internal audits are completed as per the internal audit schedule. This aspect of the previous audit finding has been addressed. Implementation of corrective actions is the responsibility of the manager/director. The relative/resident survey (May/June 2017) is documented as presented to and discussed with family and residents. This aspect of the previous audit finding has been addressed. Clinical guidelines are in place to assist care staff with safe and timely delivery of care. Policies and procedures are reviewed regularly and include reference to interRAI assessments where applicable. Falls prevention strategies are in place, that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an accidents and incidents reporting policy. When an incident occurs the staff member discovering the incident completes the accident/incident form. Twelve incident forms reviewed demonstrated that all appropriate clinical follow-up and investigation had occurred following incidents. The RN conducts clinical follow-up of residents following an incident/accident (link 1.3.3.1). The previous certification audit finding has been addressed. The RN investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at the three monthly staff meetings. Discussions with the manager/director confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one administration person, one cook, one cleaner, one RN and one caregiver). Not all staff files reviewed had a copy of required documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. A current copy of the RN practicing certificate was sighted. An orientation programme includes organisational structure and policies and general information for staff. Staff are orientated to their area of work and complete competencies relevant to their role. Staff interviewed stated that new staff are adequately orientated to the service, however not all staff files evidenced completed orientations. There is a documented annual training plan. There is an attendance register for each training session and an individual staff member record of training. Not all mandatory training has been completed within the required two year period.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably	FA	Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents' needs. The RN works for 12 hours a week, six hours on both Thursday and Friday. The RN is on-call 24/7 for any clinical issues and also lives close to the facility. The manager/director is on call 24/7 for any facility or staffing issues. There are two caregivers on the morning shift and afternoon shift, there is one caregiver on the night shift. The manager/director and the housekeeper are qualified caregivers and provide cover between shifts from 1.00pm to 2.30pm. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Residents and relatives interviewed confirm that there are sufficient staff on site

qualified/skilled and/or experienced service providers.		at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	Progress notes are documented by RN and care staff. Progress notes did not document regular review by the RN (link 1.3.3.3) and staff did not always document time and designation with each progress note entry
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN and senior caregivers responsible for the administration of medications have completed annual competencies and medication education. Medications (blister packs) are checked on arrival by the RN and any pharmacy errors recorded and fed back to the supplying pharmacy. All medications are stored safely. All eye drops are dated on opening. There were no self-medicating residents on the day of audit. Standing orders were not in use. The service has good communication and access to the GP at the medical centre. The RN works part-time as a practice nurse for the medical centre. Ten medication charts and administration signing sheets were reviewed. Prescribing of medication met legislative requirements. A caregiver was observed administrating medications and was compliant in the medication administration procedure. Policies for controlled medications document a safe practice that includes two medication competent staff signing for medications, one being a RN when a RN is on duty. There were no regular controlled drugs in use and very infrequent use of as required controlled drugs. A RN had been on duty each time these were administered for the last six months.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	All meals at Voguehaven rest home are prepared and cooked on site. There is a four weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the two dining areas. A tray service is available. Dietary needs are known with individual likes and dislikes accommodated. Pureed, soft foods and diabetic desserts are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures (including poultry) are recorded daily. The previous finding has been addressed. All foods were dated and stored correctly. Staff working in the kitchen has completed training in food safety and hygiene and chemical safety. A cleaning schedule is maintained.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	In four of five files reviewed, the long-term care plan is completed within three weeks of admission by the RN (link 1.3.3.3). Care plans describe the resident goals, supports and interventions required to meet desired goals, however there was a shortfall around documented supports and interventions for residents with identified falls risk, pain and diabetes management. The previous finding remains. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. There was evidence of allied health care professionals involved in the care of the resident. Short-term care plans are used for changes in health status.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the RN initiates a review (link 1.3.3.1) and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families reported they were kept informed of any changes to resident's health status. Resident files reviewed included a communication with family record, which evidenced family notification for infections, accident/incidents, GP visits, care plan reviews and any changes to health status. Wound management policies and procedures are in place. Staff report there are adequate continence supplies and dressing supplies. Supplies of these products were sighted in store cupboards. There were four wounds (one resident with multiple skin cancer lesions and one resident with two small healing ulcers on feet and one sacral pressure injury (recurring and assessed by RN) on the day of audit. Wound assessments and evaluation forms are completed for wounds. Staff are knowledgeable about pressure injury prevention and management and attended wound care (included PIs) education. The RN is a current practice nurse and has attended wound care and pressure injury education. The RN interviewed works closely with the GP and could describe the referral process to a wound specialist or continence nurse if required. Short-term care plans document appropriate interventions to manage short-term changes in health such as infections. Monitoring forms are used for example observations, behaviour, blood sugar levels and neurological signs.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is an activity plan that meets the group and individual preferences of the resident group. The delivery of the activity plan is shared between the administrator (for documentation), a designated caregiver who incorporates activities into their day as a caregiver. The Monday to Friday programme is flexible and provides a variety of activities that are meaningful to the residents. The residents have a choice of a morning (11.00am to 12.00am) and afternoon (1.00pm to 3.00pm) activity. The programme is varied and interesting with board games, quizzes, reading, balloon tennis, crafts, movies, entertainment, walking, exercises and pampering. Links with the community involves visits from local kindergartens and schools, daily visits with animals coming in to the facility, RSA visits, music entertainers, card groups, crafts, happy hour, and attending musical events. There are two van outings per week to explore the local region. Residents are supported to attend their church. A social history and activity plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six monthly with the LTCP review by the RN. The previous finding has been addressed. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. Residents and families interviewed stated they were happy with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In the files sampled, initial care plans were evaluated by the RN within three weeks of admission. The long-term care plans were evaluated at least six monthly or earlier if there is a change in health condition. There was at least a three monthly review by the GP. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the RN reviews and initiates any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness, which expires on 1 April 2018.
Standard 3.5:	FA	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is

Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		collected and analysed monthly to identify areas for improvement or corrective action requirements. There is close liaison with the GP who advises and gives feedback to the service. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. Infections are graphed and fed back to staff. Definitions of infections are in place appropriate to the complexity of service provided. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Low	Voguehaven rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The manager/director and RN share the restraint coordinator role. On the day of the audit there were no residents assessed as requiring restraint and one resident using an enabler (bed rail). The resident file reviewed did not have a signed consent form. Restraint/enablers are discussed at the staff meeting. The caregivers interviewed were knowledgeable in the use of an enabler.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	There are human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one administration person, one cook, one cleaner, one RN and one caregiver). There were documentation gaps within staff files around employment agreements, job descriptions, orientations and performance appraisals. Staff reported completing an orientation.	Five staff files were reviewed. There was no documented evidence of an employment agreement in one out of five files, job description were missing in three out of five files, orientation checklist were not included in three out of five files and performance appraisals were not evidenced to be completed in two out of five files reviewed.	Ensure that all staff files have a copy of an employment agreement, job description, completed orientation checklist and performance appraisal

				90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	There is an annual training plan that is being implemented. There is an attendance register for each training session and an individual staff member record of training. Not all mandatory training has been completed within the required two year period. The service has recently commenced the new online training programme (MyPath) with Careerforce and staff also complete competencies.	Not all mandatory training has been completed within the required two year period. The mandatory training not completed during this period was abuse and neglect, nutrition/hydration, pain management, privacy/dignity, end of life/death, the aging process and spirituality/counselling.	Ensure that all mandatory training is provided within the required two year period. 90 days
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Progress notes are documented by RN and care staff. Progress notes did not document regular review by the RN (link 1.3.3.3) and staff did not always document time and designation with each progress note entry	In five of five files reviewed staff did not always document time and designation in the progress notes at each entry	Ensure progress note entries are documented with name, designation, time and date clearly recorded 180 days
Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to	PA Moderate	Caregiver's progress notes were brief but were documented every shift. Where the registered nurse documented in progress notes, there were detailed and described specific interventions or encounters. However, RN input was not consistency documented and the progress notes contained gaps of up to two months where no nursing interventions/reviews had been documented by the RN.	Four of five resident files sampled did not contain documented evidence of regular assessment/input by the RN. Progress notes had periods ranging from one to two months where no nursing assessments or reviews were documented.	Ensure that RN follow up, (assessments and reviews) are completed and documented regularly in the progress notes.

perform the function.				60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Each of the five files sampled contained an initial assessment within 24 hours and long-term care plans. One of five care plans had not been completed within 3 weeks. All resident files reviewed had a suite of paper-based risk assessments completed and recent (within last 6 months) review by the RN. Long-term care plans (LTCP) had been updated. There were gaps noted around the completion of interRAI, therefore the previous finding remains open. The one RN employed for twelve hours per week is trained in interRAI assessments. All residents who were under the care of the house GP had contractual timeframes in relation to admission assessments met.	(i)Two of five (admitted since October 2016) files did not have interRAI assessment documented within three weeks of admission. (ii) Four of five (been in facility since 1996, 2010, 2015, October 2016) resident files reviewed did not have a current interRAI assessment completed by the RN, one had no interRAI (been in the facility since October 2016). (iii) One LTCP has not been completed with 3 weeks of admission	Ensure that contractual timeframes around resident assessments and care plans are met. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	The RN has completed risk assessments on admission in all resident files sampled. The care plans describe the supports and interventions required around activities of daily living, for example, skin integrity, wounds, continence, mobility and nutrition. A shortfall was identified around required supports for residents identified with high falls risk, management of pain and diabetes.	Care plans did not reflect the supports and interventions required to achieve outcomes of assessments for (i) falls prevention strategies for one of five residents identified with high falls risk, (ii) pain management plan for one of five residents with a wound who identified pain and (iii) one resident file did not document diabetes management in sufficient detail (no instruction re management of hypo/hyperglycaemia for a diabetic on insulin).	Ensure care plans describe the required supports and interventions identified by the assessment process. 60 days
Criterion 2.1.1.4 The use of enablers	PA Low	Voguehaven rest home has policies and procedures on restraint minimisation and safe practice. Policy	There was no updated restraint register confirming the one resident using an	Ensure that an up-to-date

shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.		includes guidelines and definitions for use of enablers and restraint. The manager/director and RN share the restraint coordinator role. On the day of the audit there was one resident using an enabler (bed rail). The resident file reviewed did not have a signed consent form.	enabler. The resident using an enabler did not have a signed consent form	restraint register is in place. A consent form is completed and signed for the resident using an enabler. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.